STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155494	A. BUILDING		COMPLETED 03/10/2011
		100404	B. WING	ADDRESS SWILL STATE OF SAN SORE	00/10/2011
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE TODD DR	
WATERS	OF SCOTTSBUR	G, LLC THE		SBURG, IN47170	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
F0000	This visit was fo	or the Investigation of	F0000	Preparation and/or execution	of
	•	086763, Complaint		this plan of correction in genre or this corrective action in	al,
	IN00087154, an	d Complaint IN00087163.		particular, does not constitute admission or agreement by the	
	Complaint IN00	086763 -		facility of the facts alleged or	
	•	, due to lack of evidence.		conclusions set forth in this statement of deciciencies. The	
	Complaint IN00	0087154 -		plan of correction and specific corrective and specific coreed	
	•	, due to lack of evidence.		actions are prepared and/or executed in compliance with s	
	Complaint IN00	087163 - Substantiated.		and federal laws.	siale
	Federal/State de	ficiencies are cited at			
	F224, F225 and	F226.			
	Unrelated defici	ency cited.			
	Survey dates: M	March 8, 9, and 10, 2011			
	Facility number	: 000478			
	Provider numbe	r: 155494			
	AIM number: 10	00290430			
	Survey team:				
	Anne Marie Cra	ys RN			
	Census bed type	::			
	SNF/NF: 73				
	Total: 73				
	Census payor type:				
	Medicare: 5				
	Medicaid: 64				
	Other: 4				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155494			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  COMPLETED  3/10/2011					
	VIDER OR SUPPLIER OF SCOTTSBURG	S, LLC THE	STREET ADDRESS, CITY, STATE, ZIP CODE  1350 N TODD DR  SCOTTSBURG, IN47170					
(X4) ID PREFIX TAG	(EACH DEFICIENC REGULATORY OR I	ARY STATEMENT OF DEFICIENCIES ID ICIENCY MUST BE PERCEDED BY FULL PREFIX RY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE		
	Sotal: 73 Sample: 9							
fi		es also reflect state accordance with 410 IAC						
Q	Quality review 3/15/	11 by Suzanne Williams, RN						

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE SURVEY	Y
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPLETED	
		155494	B. WIN			03/10/2011	
			<u> </u>		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1350 N	TODD DR		
	OF SCOTTSBURG	G, LLC THE			SBURG, IN47170		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	<b>I</b>	(X5)
PREFIX	` ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	E	PLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	<u> </u>		ATE
F0224		ew and record review, the	F02	24	F224   PROHIBITMISTREATMENT/N		5/2011
SS=D	=	ensure a resident was free			GLECT/MISAPPROPRIATION		
		nt [Resident G], for 1 of			is the intent of this facility to		
	4 residents review	wed for abuse, in a			ensure all residents' remain fre	e	
	sample of 9.				of mistreatment.1. Actions		
					Taken:A. In regards to Reside		
	Findings include:	:			G, the Licensed Nurse identifice was terminated on 2/23/11.2.	ea	
	C				Residents Identified:A. No other	er	
	On 3/8/11 at 10:1	15 A.M., the Director of			allegations of abuse have bee	l l	
		rovided the current			reported.3. Measures Taken:/		
		ated 1/07, on Abuse			All staff were in-serviced on th	e	
		policy included, "It is the			facility Abuse Policy and		
		ility to keep residents			Procedure and reporting requirements and all forms/typ	96	
		-			of abuse were reviewed.4. Ho		
		al, mental, sexual, verbal			Monitored:A. DON/Designee	I .	
		al abuse at all times.			immediately notify of, and revi	ew	
	_	e, neglectis one of the			with the Administrator, all		
		bilities of the long-term			allegations of abuse as any occur, to ensure compliance w	ith	
		facility has provided			the Abuse policy/procedure ar	I .	
	_	ents, families, and staff			the safety of all residents.B.	<u> </u>	
		ohibit abuse events,			ADM/Designee will review all		
	along with ongoi	ng education"			allegations/investigations durir		
					daily QA meeting to ensure an	a	
	The clinical reco	rd of Resident G was			be responsible for on-going compliance.C. Administrator v	<sub>vill</sub>	
	reviewed on 3/9/	11 at 10:30 A.M.			review allegations/investigation		
	Diagnoses includ	led, but were not limited			with the Medical Director at		
	_	behavior disturbance,			Quarterly QA meeting.5. This		
	*	ase, mood disorder, and			plan of correction constitutes of	I .	
	anxiety.	,			credible allegation of complian with all regulatory requirement		
					Our date of compliance is Mar		
	The most recent	Minimum Data Set			25, 2011.		
		nt, dated 1/28/11,					
		nt G scored a 1 out of 15					
	in a cognitive ass	sessment, and was totally					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING			COMPLETED	
		155494	B. WIN			— I	03/10/2011	
NAME OF I	DROVIDED OD GLIDDLIEF		<u> </u>		DDRESS, CITY, STATE, Z	IP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	C		1350 N	TODD DR			
	OF SCOTTSBUR	•			SBURG, IN47170			
(X4) ID		TATEMENT OF DEFICIENCIES	_	ID	PROVIDER'S PLAN OF		(X5)	
PREFIX	`	ICY MUST BE PERCEDED BY FUL	I	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TO DEFICIENCY	HE APPROPRIATE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATIO	JN)	TAG	DEFICIENC	.,	DATE	
	*	e staff for dressing,						
	hygiene and bath	-						
		eated Resident G was						
		tinent of bowel and						
	bladder.							
		00 A.M., the Director of						
		d a copy of an abuse						
	_	ed to the Indiana State						
	•	Iealth, dated 2/23/11. The	e					
	_	luded: "Incident Date,						
	2-20-11, Inciden	t Time, Unknown,						
	Resident Name [	Resident G]Diagnoses,	,					
	DementiaAlzh	eimer'sBrief						
	Description of Ir	ncident, [LPN # 1] told						
	another nurse tha	at he sat Resident down in	n					
	chair 'hard.' Type	e of Injury/Injuries, none						
	• • • • • • • • • • • • • • • • • • • •	uises to buttocks. No						
		ss notedPreventative						
		, Re-inservice and						
	· ·	on abuse policy [and]						
	timely reporting.							
		stigation carried out by						
		Assistant Director of						
	Nursing], Adm.							
		ble to substantiate"						
	i inegation - una	ore to substantiate						
	An attached type	ed statement by the DoN,						
	J 1	idicated, "Spoke with						
		-						
		NA who worked with						
		nday 2-20-11 when						
	_	appose [sic] to take place						
	She stated that []	Resident G] had slept						
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event I	D: M2I011	Facility I	D: 000478 If	continuation shee	et Page 4 of 26	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	IULTIPLE CO	NSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	ILDING				
		155494	B. WIN				03/10/2	U I T
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, 2	ZIP CODE		
				1	TODD DR			
	OF SCOTTSBURG			SCOTTS	SBURG, IN47170			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN O			(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACT	THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC	.Y)		DATE
		d when he awoke he was						
		ative. She said that [LPN						
	-	ident to his room. When						
		out of the room [CNA #						
	-	ery mad, and said						
		ked his elbow and then						
	fell to the ground							
	[Resident G] was trying to break his arm.							
	[CNA # 1] then went on to say that [LPN							
	# 1] said in a sard	castic voice, 'So I had to						
	gently place him	in his chair.' She did not						
		g, but did say [LPN # 1]						
		and was sarcastic when he						
	said 'Gently.'"							
	Suru Genery.							
	An additional typ	ped statement by the						
	DoN, dated 2/22/	/11, indicated,						
		ote from charge nurse						
		s date. He stated that						
		ht to his attention that on						
		PN # 1] told [LPN # 3]						
	, , ,	llammed [Resident G] in						
		all to [LPN # 3] at this						
		ned her on the events of						
	•	ne stated that [LPN # 1]						
		init and proceded [sic] to						
	=	ident G] had just locked						
		w in with his and he tried						
	_	lent G] from his arm						
		on to say that he picked						
		and slammed him in a						
	•	aid well no maybe I sat						
	him down a little	e hard. She said [LPN # 1]						
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	M2I011	Facility II	D: 000478 I	f continuation sh	eet Pa	ge 5 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING		COMPL	
		155494	B. WIN	G		03/10/2	011
NAME OF I	PROVIDER OR SUPPLIER		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				1350 N	TODD DR		
	S OF SCOTTSBUR			<u>.</u>	SBURG, IN47170		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	<b>†</b>	R LSC IDENTIFYING INFORMATION)	+	TAG	BEFFERET		DATE
	1	Educated [LPN # 3] on					
	_	use. Informed her that					
	any allegation needs to be reported to on						
	call manager at that time so we can begin						
		mediately and send the					
	staff member ho						
	1	repeated out [sic] abuse					
		to intervene and follow up					
	on all allegations	s." The DoN indicated at					
	that time that LP	PN # 3 should have					
	immediately rep	orted the incident to her,					
	and was inservice	ed. The DoN indicated					
	the CNA involve	ed "really didn't witness					
	anything." The I	DoN indicated the nurse					
	manager was the	e person who informed her					
	on 2/22/11.	•					
	On 3/9/11 at 3:1	0 P.M., CNA # 1 was					
	interviewed rega	arding Resident G's					
	1	/11. CNA # 1 indicated,					
	"I had stepped or	ff of the unit. [LPN # 1]					
		N # 3] that he took care of					
	_	wasn't sure what he					
	1 -	1] can be sarcastic. He					
	1 -	other nurse about it at the					
		said he took [Resident G]					
		put him in his chair. [LPN					
	1	ent G] should start to calm					
	down now."	on G should start to cann					
	down now.						
	On 3/9/11 at 10:	15 P.M., LPN # 3 was					
		arding Resident G's					
	_	/11. LPN # 3 indicated,					
	1110100111 011 2/20	in Diring maleutes,					

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/28/2011 FORM APPROVED OMB NO. 0938-0391

l	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING		COMPL	
		155494	B. WIN			03/10/2	011
NAME OF I	PROVIDER OR SUPPLIER	8		1	ADDRESS, CITY, STATE, ZIP CODE		
WATERS	S OF SCOTTSBURG	G, LLC THE			TODD DR SBURG, IN47170		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	, i	CY MUST BE PERCEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE)		DATE
	1	y two nurses here, and that unit. [LPN # 1]					
ļ		d me that he slammed					
ļ							
	I	wn and set him down					
		ndicated LPN # 1 was					
	1	N # 3 indicated she told ne incident "when he					
		s on his arms." LPN # 3					
		ought LPN # 2 then wrote					
	a letter to the Do	•					
		IN.					
	On 3/10/11 at 9::	30 A M. during					
	interview, the Do						
ļ		ough skin assessment on					
ļ	Resident G on 2/	_					
		ident had multiple					
		his arms from admission,					
		few days previous to that,					
		caused additional					
	1	N indicated she focused					
		sing to the buttocks, due					
	1 *	of "sitting down hard."					
	io ino statement	or siming down natu.					
	On 3/10/11 at 1:0	05 P M during					
		oN indicated she received					
		# 2 had written on					
		g the alleged abuse on					
	1	also inserviced LPN # 2					
	· ·	cility's abuse procedure.					
		, » «« «»» provadio.					
	This federal tag	relates to Complaint					
	IN00087163.						

000478

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:  155494			(X2) MULTIPLE CONSTRUCTION  A. BUILDING B. WING  (X3) DATE SURVEY COMPLETED 03/10/2011					
NAME OF F	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE TODD DR	<b>I</b>			
	OF SCOTTSBURG		SCOTTSBURG, IN47170					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLETION			
	3.1-28(a)							

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE			(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPLETED
		155494	B. WIN			03/10/2011
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER				TODD DR	
WATERS	OF SCOTTSBURG	G, LLC THE	SCOTTSBURG, IN47170			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
F0225	Based on intervie	ew and record review, the	F02	25	F225 Investigate/report	03/25/2011
SS=D	facility failed to	ensure staff reported			allegations/individualsIt is the	
	immediately to th	ne Administrator an			intent of this facility for staff to report immediately to the	
		ed physical abuse from a			Administrator, violations involv	ina
		a resident [Resident G],			mistreatment, neglect, or abus	- 1
		reported a resident's			and residents are protected, a	
	_	*			it is reported per the	
	_	ising of an unknown			requirements. This includes a	II
		C], for 2 of 4 residents			alleged physcial abuse from a	
	reviewed for abu	se, in a sample of 9.			staff member to a resident and	i all
					resident's identified with large areas of bruising of an unknow	ın l
	Findings include:				origin1. Actions Taken:A. In	/ <sup>11</sup>
					regards to Resident G, an	
	1. On 3/8/11 at 1	0:15 A.M., the Director			investigation was completed a	nd
		provided the current			the allegation of abuse could r	not
	0.2	ated 1/07, on "Response			substantiated but the suspect	
	to Suspected Abu				LPN was terminated 2/23/11.E	3.
	-	<del>-</del>			In regards to Resident C, an	
	·	Misappropriation of			investigation was completed with a finding that the	
		y." The policy included:			discoloration was self inflicted.	
	_	s of abuse must be taken			Interventions were put in place	
	seriously and mu	st be investigated. The			Resident C has since had a	
	reporting and inv	restigation policies and			pre-planned discharge to anot	
	procedures must	be fully enforcedAbuse			facility.2. Residents Identified	:A.
	can be manifeste	d in various, subtle			No other investigations have	
		mples include: Physical			been initiated and no other	
	-	ource of the injury was			reports of abuse have been made.3. Measures Taken:A.	AII
		any person or the source			Department heads in-serviced	
	,	J 1			Abuse Protocol and	
		ld not be explained by the			policy/procedure; including the	e
		ne injury is suspicious			immediate notification of the	
		atent of the injury or the			Administrator.B. In-services	
	location of the in	juryAll incidents			conducted for all staff related t	
	resulting in an in	jury must be fully			abuse policy including immedinotification of the Administrato	
		etermine the cause of the			and removing accused person	
	-	to prevent recurrence in			from the facility during the	
		1			, , ,	
					!	

	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155494	A. BUI	LDING		03/10/2011	
		155454	B. WIN			03/10/2011	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
WATEDS	OF SCOTTSBURG	3 LLC THE			TODD DR SBURG, IN47170		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE DATE	
1110	the futureAny a				investigation, etc.4. How	5.112	
	involving mistrea	<del>-</del>			Monitored:A. DON/IDT will		
	_	immediately reported to			immediately notify the		
		r, Director of Nursing or			Administrator and review/repo	rt	
	designee(s)"	i, Director of Nursing of			all abuse allegations as any occur, to ensure compliance w	vith	
	ucsignec(s)				abuse policy/procedure and		
	2. On 3/8/11 at 1	11:00 A.M., the Director			reporting guidelines.B. ADM/I will review all allegations of	DT	
		ded a copy of an abuse			abuse, when and if any occur,		
	• •	ed to the Indiana State			during daily QA stand-up mee		
	Department of H	ealth, dated 2/23/11. The			to ensure and be responsible to	for	
	•	luded: "Incident Date,			on-going compliance.C. All Investigations and results will	ho	
	2-20-11, Incident	t Time, Unknown,			reviewed with the Medical	DE	
	Resident Name	Resident G]Diagnoses,			Director at Quarterly QA		
	DementiaAlzhe	eimer'sBrief			meeting.5. This plan of		
	Description of In	cident, [LPN # 1] told			correction constitutes our cred allegation of compliance with a	l l	
	•	at he sat Resident down in			regulatory requirements. Our	111	
	chair 'hard.' Type	e of Injury/Injuries, none			date of compliance is March 2	5,	
	sustained. No bru	uises to buttocks. No			2011.		
	emotional distres	ss notedPreventative					
	Measures Taken,	Re-inservice and					
	Re-educate staff	on abuse policy [and]					
	timely reporting.	2/23/11 - LPN					
		stigation carried out by					
		ssistant Director of					
	Nursing], Adm. [						
		ole to substantiate"					
	_						
	An attached type	d statement by the DoN,					
		dicated, "Spoke with					
	·	NA who worked with					
		nday 2-20-11 when					
	_	appose [sic] to take place.					
		Resident G] had slept					
		<u> </u>					

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	TE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING		COMPLETED		
		155494	B. WIN			03/10/20	011	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	l		
NAME OF I	PROVIDER OR SUPPLIER	-			TODD DR			
WATERS	OF SCOTTSBURG	G, LLC THE		1	SBURG, IN47170			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	most of night and	d when he awoke he was						
	somewhat comba	ative. She said that [LPN						
	# 1] took the resident to his room. When [LPN # 1] came out of the room [CNA #							
		ery mad, and said						
		ked his elbow and then						
		I. He said that he knew						
		s trying to break his arm.						
		went on to say that [LPN						
		castic voice, 'So I had to						
	_	in his chair.' She did not						
		, but did say [LPN # 1]						
		and was sarcastic when he						
	said 'Gently.'"							
	An additional typ	ped statement by the						
	DoN, dated 2/22	/11, indicated,						
	"Received a no	te from charge nurse						
	[LPN # 2] on this	s date. He stated that						
	[LPN # 3] broug	ht to his attention that on						
	Sunday night [LI	PN # 1] told [LPN # 3]						
		lammed [Resident G] in						
		all to [LPN # 3] at this						
		ned her on the events of						
	1	e stated that [LPN # 1]						
		init and proceded [sic] to						
		ident G] had just locked						
	_	w in with his and he tried						
	-	lent G] from his arm						
	_	_						
	-	on to say that he picked						
	1 1 1	and slammed him in a						
		aid well no maybe I sat						
	him down a little	hard. She said [LPN # 1]						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CON		(X3) DATE SURVEY COMPLETED		
ANDTLAN	OI CORRECTION	155494	A. BUI	LDING			03/10/2	
		100484	B. WIN				03/10/2	011
NAME OF I	PROVIDER OR SUPPLIEF			1	DDRESS, CITY, STATI	E, ZIP CODE		
				1	ODD DR			
WATERS	S OF SCOTTSBUR				BURG, IN47170			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID		N OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE A CROSS-REFERENCED	TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIE	ENCY)		DATE
	1	Educated [LPN # 3] on						
	1 ~	use. Informed her that						
		eeds to be reported to on						
		hat time so we can begin						
	investigation immediately and send the							
	staff member home. She voiced							
	understanding. I repeated out [sic] abuse							
	policy and how t	to intervene and follow up						
	on all allegations	s." The DoN indicated at						
	that time that LP	N # 3 should have						
	immediately rep	orted the incident to her,						
	and was inservic	ed. The DoN indicated						
	the CNA involve	ed "really didn't witness						
		OoN indicated the nurse						
	1 '	person who informed her						
	on 2/22/11.	<b>P</b>						
	011 27 227 111.							
	On 3/9/11 at 3:10	0 P.M., CNA # 1 was						
		rding Resident G's						
	_	/11. CNA # 1 indicated,						
		ff of the unit. [LPN # 1]						
		N # 3] that he took care of						
	I -	wasn't sure what he						
	1	can be sarcastic. He						
	-	other nurse about it at the						
		aid he took [Resident G]						
	1	put him in his chair.						
		Resident G] should start						
	to calm down no	W.''						
	0 2/0/11 : 10	15 D.M. I DN " 2						
		15 P.M., LPN # 3 was						
	1	rding Resident G's						
	incident on 2/20/	/11. LPN # 3 indicated,						
FORM CMS-2	2567(02-99) Previous Version	ons Obsolete Event ID:	M2I011	Facility II	000478	If continuation s	heet Pa	ge 12 of 26

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155494			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 03/10/2011	
NAME OF I	PROVIDER OR SUPPLIER		B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
	S OF SCOTTSBUR			1	TODD DR SBURG, IN47170		
(X4) ID		TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	·	y two nurses here, and that unit. [LPN # 1]					
		d me that he slammed					
	[Resident G] down and set him down						
	I	indicated LPN # 1 was					
	very angry. LPN	N # 3 indicated she told					
		ne incident "when he					
		s on his arms." LPN # 3					
		ought LPN # 2 then wrote					
	a letter to the Do	on.					
	On 3/10/11 at 9:	30 A.M., during					
	interview, the De	oN indicated she					
	performed a thor	ough skin assessment on					
		/22/11. The DoN					
		ident had multiple					
		his arms from admission,					
		few days previous to that,					
	_ ·	caused additional  N indicated she focused					
		sing to the buttocks, due					
	1 ^	of "sitting down hard."					
		<u>J</u>					
	On 3/10/11 at 1:	05 P.M., during					
		oN indicated she received					
		# 2 had written on					
	_	g the alleged abuse on					
	· ·	also inserviced LPN # 2					
	regarding the lac	cility's abuse procedure.					
	3. The closed cli	nical record of Resident					
	C was reviewed	on 3/9/11 at 12:10 P.M.					
	Diagnoses include	ded, but were not limited					

000478

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING		COMPLETED	
		155494	B. WIN			03/10/2	011
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	<u>t</u>		1350 N	TODD DR		
	OF SCOTTSBURG	G, LLC THE			SBURG, IN47170		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	to, Dementia wit						
	Disturbance. The resident was admitted to						
	one of the locked	d units in the facility on					
	2/23/11.						
		cluded the following					
	notations:						
	3/1/11 at 8:00 P	M.: "Called to rm [room]					
		sing resident for bed					
	1 *	purple bruises. # 1 Lt					
		scrotum measures 14 x 6					
		. # 2 Rt. [right] lat.					
	1 2 2	easures 9.5 x 5 cm.					
	Resident unable						
	causeMessage	left for DoN."					
	3/2/11 at 10:30 A	AM·" Upon					
		ruising on buttock et					
		sing was found in anal					
	area as well"	sing was round in and					
	area as well						
	3/2/11 at 11:30 A	A.M.: "This nurse was					
	advised of bruise	es on res's [resident's] Rt.					
		uttock by 2nd shift nurse					
		tRes. was assessedAt					
	• •	g of [left] knee was					
	notedMD was						
	notedwiD was	phoneu					
	On 3/8/11 at 1:00	0 P.M., the DoN provided					
		at Report," dated 3/2/11,					
	regarding Reside	-					
	-	ef description of Incident,					
	moradou,Dire	accompaint of moracit,					

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/28/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155494		(X2) MULTIPLE CO	ONSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED 03/10/2011		
	PROVIDER OR SUPPLIER		B. WING 03/10/2011  STREET ADDRESS, CITY, STATE, ZIP CODE  1350 N TODD DR  SCOTTSBURG, IN47170				
	SUMMARY S' (EACH DEFICIEN REGULATORY OR  Area of discolora to scrotumInve Complete assess: other areas" W # 4 and LPN # 5  On 3/9/11 at 10:: interviewed rega Resident C. LPN worked the morn indicated the nig Resident C had of indicated when s "was astounded," and informed the the previous shift the physician or indicated the resishe was aware of indicated "he had with some force.  On 3/9/11 at 2:30 indicated she had related to the res 3/1/11. The DoN even the person of	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) Attion noted from coccyx estigation started. International content of the	1350 N	TODD DR	TION LD BE	(X5) COMPLETION DATE	
	3.1-28(d)						

000478

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE S COMPLI	
	155494	B. WIN			03/10/20	011
NAME OF PROVIDER OR SUPPLIER WATERS OF SCOTTSBURG	G, LLC THE	'	1350 N SCOTT	ADDRESS, CITY, STATE, ZIP CODE TODD DR 'SBURG, IN47170	-	
PREFIX (EACH DEFICIEN	FATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
facility failed to a immediately to the incident of alleger staff member to a and immediately large area of bruit origin [Resident the policy for abecausing the Adminmediately inform of 4 residents revesample of 9.  Findings include  1. On 3/8/11 at 1 of Nursing [DoN facility policy, dated to Suspected Abecausing the Adminstreatment, or Resident Propert "All allegations seriously and mure porting and inverse procedures must can be manifested waysSome exause Evidence:the senot observed by a of the injury coursident: AND the	rmed of allegations, for 2 riewed for abuse, in a  0:15 A.M., the Director provided the current ated 1/07, on "Response"	F02	26	F226 Develop and Implement/Abuse/Neglect, etc PoliciesIt is the intent of this facility for staff to report immediately to the Administration any/all alleged violations involved including physcial abuse from staff member to a resident, and any identified large areas of bruising of an unknown origin. is also the intenet of this facility for the policy for abuse to be specific for immediately inform the Administrator of all allegation fabuse. 1. Actions Taken: A. Department heads in-serviced Abuse Protocol and policy/procedure; including immediate notification of the Administrator of all allegations abuse; including physical abuse from a staff member to a resident and any identified large areas bruising of an unknown origin. Residents Identified: A. No oth residents have been identified and no other reports of abuse have been made. 3. Measures Taken: A. In-services conducted for all staff on Abuse Protocol Abuse Policy and Procedure; including immediate notification the Administrator of all allegation abuse; such as, physical abuse from a staff member to a resident and any identified large areas bruising of an unknown origin. How Monitored: A. DON/IDT wimmediately notify the Administrator to report/reviews.	or, ving e, a d It y ing ons All on of se ent of 2. er ed and n of ons use ent of 4. vill	03/25/2011

<b> </b>		(X2) MULTIPLE CONSTRUCTION			(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155494	A. BUILD	ING		COMPL 03/10/2	
		100707	B. WING		PDDDGG GYMY GM :==	03/10/2	011
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
   WATERS	S OF SCOTTSBURG	G. LLC THE			SBURG, IN47170		
(X4) ID		FATEMENT OF DEFICIENCIES	$\dashv$	ID I			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PI	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	1	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
	location of the in	juryAll incidents			abuse allegation as any occur,		
	resulting in an in	jury must be fully			ensure compliance with adher	ing	
	investigated to de	etermine the cause of the			to policy/procedure for abuse protocol. B. Administrator will		
	incident and how	to prevent recurrence in			review all investigations in dail		
	the futureAny a	alleged violation			QA meeting to ensure and be		
	involving mistrea	atmentabuse,			responsible for ongoing compliance. This will be		
	~	immediately reported to			ongoing.C. Administrator will I	oe	
	the Administrato	r, Director of Nursing or			review all		
	designee(s)"				allegations/investigations with		
					Medical Director at the quarter QA meeting. This will be	ly	
		1:00 A.M., the Director			on-going.5. This plan of		
	J	ded a copy of an abuse			correction constitutes our cred		
		ed to the Indiana State			allegation of compliance with a	all	
	_	ealth, dated 2/23/11. The			regulatory requirements. Our date of compliance is March 2	5	
	"	luded: "Incident Date,			2011.	J,	
	· ·	t Time, Unknown,					
	· -	Resident G]Diagnoses,					
	DementiaAlzho						
	_	cident, [LPN # 1] told					
		at he sat Resident down in					
		e of Injury/Injuries, none					
		uises to buttocks. No					
		ss notedPreventative					
	l	Re-inservice and					
		on abuse policy [and]					
	timely reporting.						
		stigation carried out by					
	'	ssistant Director of					
	Nursing], Adm. [						
	Allegation - unat	ole to substantiate"					
	An attached toma	d statement by the DoN,					
	1	dicated, "Spoke with					
	uaicu 2/22/11, III	uicaicu, spoke wiiii					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M A. BUI		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155494	B. WIN			03/10/2	011
	PROVIDER OR SUPPLIER		1	1350 N	ADDRESS, CITY, STATE, ZIP CODE TODD DR SBURG, IN47170	1	
				<u>l                                    </u>	SBURG, IN47 170		
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	ATE.	DATE
	[CNA # 1] the C	NA who worked with					
	[LPN # 1] on Sunday 2-20-11 when						
	allegation was suppose [sic] to take place.						
	_	Resident G] had slept					
		d when he awoke he was					
		ative. She said that [LPN					
	_	dent to his room. When					
		out of the room [CNA #					
		ery mad, and said					
	1	ked his elbow and then					
		I. He said that he knew strying to break his arm.					
	*	went on to say that [LPN					
		castic voice, 'So I had to					
	_	in his chair.' She did not					
		, but did say [LPN # 1]					
		and was sarcastic when he					
	said 'Gently.'"	ind was sareastic when he					
	said Gentry.						
	An additional tvr	ped statement by the					
	DoN, dated 2/22	•					
		te from charge nurse					
		s date. He stated that					
		ht to his attention that on					
	Sunday night [LI	PN # 1] told [LPN # 3]					
	that he had just s	lammed [Resident G] in					
	a chair. Placed ca	all to [LPN # 3] at this					
	time and question	ned her on the events of					
		e stated that [LPN # 1]					
		nit and proceded [sic] to					
	_	ident G] had just locked					
	-	w in with his and he tried					
	to remove [Resid	lent G] from his arm					

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155494			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 03/10/2011	
	DE CLARED CO. ST. ST.	<u> </u>	D. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF	PROVIDER OR SUPPLIE	₹		1350 N	TODD DR		
	S OF SCOTTSBUR			SCOTT	SBURG, IN47170		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL  R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	TE	COMPLETION DATE
IAG	•	on to say that he picked		IAG			DATE
	1	and slammed him in a					
	1 2 1	aid well no maybe I sat					
	1	e hard. She said [LPN # 1]					
	1	Educated [LPN # 3] on					
	1	use. Informed her that					
	1	eeds to be reported to on					
	1 '	that time so we can begin					
	investigation im	mediately and send the					
	staff member ho	me. She voiced					
	understanding. I	repeated out [sic] abuse					
	policy and how	to intervene and follow up					
	on all allegation	s." The DoN indicated at					
	that time that LF	N # 3 should have					
	immediately rep	orted the incident to her,					
	and was inservice	eed. The DoN indicated					
	the CNA involve	ed "really didn't witness					
	1 .	DoN indicated the nurse					
	1 -	e person who informed her					
	on 2/22/11.						
	0 2/0/11 + 2.1	0 D.M. (D.I.A.    1					
	1	0 P.M., CNA # 1 was					
	1	arding Resident G's					
		/11. CNA # 1 indicated,					
	1	ff of the unit. [LPN # 1]					
	_	N # 3] that he took care of wasn't sure what he					
	1 -	can be sarcastic. He					
	-	other nurse about it at the					
		said he took [Resident G]					
	1	put him in his chair.					
		Resident G] should start					
	to calm down no	-					
		· · · ·					
	-						

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/28/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:					ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155494	A. BUI			03/10/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				TODD DR		
	OF SCOTTSBURG			1	SBURG, IN47170		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
TAG	On 3/9/11 at 10:1 interviewed regardincident on 2/20/ "There were only then one aide on came out and told [Resident G] down hard." LPN # 3 in very angry. LPN LPN # 2 about the found the bruises indicated she thomat letter to the Down of the Down of the Interview, the Down of the Indicated the resident G on 2/2 indica	30 A.M., during oN indicated she ough skin assessment on		TAG	DEFICIENCY)		DATE
	On 3/10/11 at 1:0 interview, the Do a letter that LPN 2/21/11 regarding 2/22/11, and had	-					

000478

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE COMPL	ETED
		155494	B. WIN			03/10/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
\A/ATED		S LLC THE		1	TODD DR SBURG, IN47170		
	S OF SCOTTSBURG			<u>.                                    </u>	SBURG, IN47 170		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAU	REGULATORT OR	ESC IDENTIF FING INFORMATION)		TAG			DATE
	C was reviewed of Diagnoses included to, Dementia with Disturbance. The one of the locked 2/23/11.  Nurses Notes inconstations:  3/1/11 at 8:00 P.I per CNA as dress found 2 lg [large [left] buttock to some [centimeters] [lateral] thigh me Resident unable causeMessage  3/2/11 at 10:30 A assessment for be [and] thigh, bruis area as well"  3/2/11 at 11:30 A advised of bruise thigh et I [left] be in morning report	e resident was admitted to a units in the facility on a luded the following  M.: "Called to rm [room] sing resident for bed a purple bruises. # 1 Lt scrotum measures 14 x 6 a scrotum measures 14 x 6 a scrotum measures 9.5 x 5 cm. to verbalize a left for DoN."  A.M.: "Upon ruising on buttock et sing was found in anal a se on res's [resident's] Rt. attock by 2nd shift nurse tRes. was assessedAt a g of [left] knee was					

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		155494	B. WING		03/10/2011
NAME OF F	PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE	•
				TODD DR	
WATERS	S OF SCOTTSBURG	G, LLC THE	SCOT	TSBURG, IN47170	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCE)	DATE
		0 P.M., the DoN provided			
		at Report," dated 3/2/11,			
	regarding Reside	*			
		ef description of Incident,			
		ation noted from coccyx			
		estigation started.			
	1 ^	ment done to check for			
		Vritten statements by LPN			
	# 4 and LPN # 5	were attached.			
		<b></b>			
		55 A.M., LPN # 4 was			
		rding the bruising on			
		# 4 indicated she			
		ning of 3/2/11. She			
	I -	ht shift nurse reported			
		lark bruising. LPN #4			
	indicated when s	she saw the bruising, she			
	"was astounded,"	" and immediately went			
	and informed the	e DoN. LPN # 4 indicated			
	the previous shif	t nurse had not notified			
	the physician or	family. LPN # 4			
	indicated the resi	ident had "not fallen" that			
	she was aware of	f, but that the bruising			
	indicated "he had	d to have fallen hard and			
	with some force.	"			
	On 3/9/11 at 2:30	0 P.M., the DoN			
		d not received a message			
		ident's bruising on			
		I indicated she was "not			
		on call that night."			
		Č			
	This federal tag 1	relates to Complaint			
		1			
				•	

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155494			(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION	COMI	(X3) DATE SURVEY  COMPLETED  03/10/2011			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  1350 N TODD DR  SCOTTSBURG, IN47170						
	S OF SCOTTSBURG SUMMARY S' (EACH DEFICIEN		1350 N	TODD DR	CTION JLD BE	(X5) COMPLETION DATE			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING		COMPL	ETED
		155494	B. WING			03/10/2	011
NAME OF I	PROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			1350 N	I TODD DR		
	OF SCOTTSBURG				ΓSBURG, IN47170 		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION DATE
F0248		on, interview, and record	F024		F248 Activities Meet		03/25/2011
	_		102	<b>T</b> O	Interest/Needs of Each		03/23/2011
SS=E	review, the facility failed to ensure an activity program was implemented for 2				Resident:It is the intent of this		
		units, with a combined			facility to have an on-going		
		dents, out of a facility			activity program on all units.1. Actions Taken:A. In regards to		
					Activities on Ruby Bay and		
	Brook Units)	iby Bay and Emerald			Emerald Brook, another full tin	ne	
	DIOOK UIIIS)				Activities person wil be		
	Findings include				implemented; allotting one full time person for each secure u		
	rindings include	•			at a minimum of four hours pe		
	On 2/9/11 at 0.50	A.M. dyning the initial			day.B. An Activity Calendar w		
		A.M., during the initial			be prominently displayed in an	1	
	*	nt Director of Nursing			appropriate visual size, easily		
		ed Ruby Bay was a			read by residents and staff on each Unit.2. OTHERS		
		r's unit for women			IDENTIFIED:A. Facility staff		
		nerald Brook was the			conducted a 100% audit of all		
	•	co-ed Alzheimer's unit.			facility residents on the other		
	· ·	activities were observed			secured unit and the open unit determine if activities of	t to	
	_	n either unit. Most of the			interest/need were available.	No	
		ther asleep in their beds,			other Units/Residents were		
	or asleep in chair	rs in the dining areas.			identified.3. MEASURES		
					TAKEN:A. In-Serviced all nurs		
		55 A.M., no activities			staff who work on secure units regards to expected activities	o, II I	
		n either of these two			participation with residents to I	be	
	locked units. At	12:10 P.M., residents			met on a daily and on-going		
	_	etting ready to eat their			basis. All nursing staff have b	een	
		the units. At 2:00 P.M.,			educated on keeping activity		
	no activities were	e observed on either of			records and assisting resident while they pursue their interes		
	these two units. I	Main activity calendars			4. HOW MONITORED:A. QA		
	were not observe	d posted in these units.			Team/IDT will monitor for		
					activities on each unit during d	laily	
	A weekly schedu	le was observed posted			QA rounds; SS/AD will monitor/review activity		
	in the dining area	a on Ruby Bay, and in an			participation during Resident		
	activity room on	Emerald Brook. The			Council meetings monthly with	۱	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 155494 03/10/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1350 N TODD DR WATERS OF SCOTTSBURG, LLC THE SCOTTSBURG, IN47170 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE the residents. This will be an schedule included: "Tuesday: 9:00 -9:30 on-going QA daily audit.B. am Remember When, 9:30-10:00 am Activity Staff will audit the Activity Exercise Walk Club, 10:00-10:45 am, Records for Residents monthly Pretty Nails, Smokin Social, 12:30-2:00 for active/passive participation from residents. This will be pm Rest Time, Smokin Social, 2:00 - 3:00 reported to the QA Committee for pm I See Something, 3:00-4:00 pm review and suggestions Courtyard Games, Smokin monthly.C. Adm/Designee will Social...Wednesday: 10:00-10:45 am review all audits at weekly QA Bingo, Smokin Social, 12:30-2:00 pm, meeting: and with Medical Director at quarterly QA meeting. Rest Time, Smokin Social, 2:00-3:00 pm This will be an on-going QA Hot Potato...Thursday, 9:00-9:30 am audit.5. This plan of correction Parachute, 9:30-10:00 am Exercise, Walk constitutes our credible allegation Club...2:00-3:00 pm Name That of compliance with all regulatory requirements. Our date of Sound...." compliance is March 25, 2011. On 3/9/11, no activities were observed on either Ruby Bay or Emerald Brook at 10:40 A.M., 12:00 P.M., 2:30 P.M., or 4:00 P.M. On 3/10/11, no activities were observed on either Ruby Bay or Emerald Brook at 9:30 A.M. On 3/10/11 at 9:55 A.M., the Activities Director [AD] and Activities Assistant indicated, "It's hard for just the 2 of us to do all 4 units." The AD indicated, "The residents on Emerald really don't like to do much. They can come to BINGO. The aides usually take care of that." The AD indicated the main activities take place outside of the locked units, and the staff

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

M2I011

Facility ID:

000478

If continuation sheet

Page 25 of 26

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY  COMPLETED		
AND PLAN OF CORRECTION		155494	A. BUILDING			03/10/2011		
<b>1</b>			B. WING STREET ADDRESS, CITY, STATE, ZIP CODE			00/10/2011		
NAME OF PROVIDER OR SUPPLIER				1350 N TODD DR				
WATERS OF SCOTTSBURG, LLC THE				SCOTTSBURG, IN47170				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)				CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE	
	could bring the residents to them if they							
	wanted to come. The activity assistant							
	indicated, "On my down time, I try and go							
	visit those units."							
	The strong differ							
	On 3/10/11 at 2:00 P.M., no activities							
	were observed on the Ruby Bay or							
	Emerald Brook units.							
	3.1-33(a)							